U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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MODULE II

Social-Emotional Development, Mental Health, and Learning

II

Module II: Overview for Trainers

This module gives a brief overview of mental health issues among teens and their potential effects in the classroom. It begins with a discussion of factors that can put teens at risk for, or protect them from, mental and emotional problems. It then looks at the continuum of problems, from wellness at one end to serious emotional disturbances at the other, and moves on to the various components of learning and behavior that can be affected by these problems. Next, slides describe the most common disorders among teens, while discussion centers on the ways that each one affects those components of learning and behavior. The final sections describe indicators that a teen may need help. An action plan for helping a student is briefly introduced. (This segment can be omitted if Module III is to follow immediately after.)

Note: Information on specific disorders is provided at three different levels. The slides provide a brief overview; the Trainer Preparation Notes give more background information; and the Appendix provides fact sheets for participants to take home for future reference.

Module II: Social-Emotional Development, Mental Health, and Learning

Contents

Module II: Goal

The goal of Module II is to give an overview of mental health issues among adolescents and their potential effects on learning and behavior.

Module II: Objectives

At the end of this module, participants will be able to:

- **Identify social-emotional factors related to positive youth development, including risk and protective factors;**
- **Understand the range of social-emotional development and its relationship to mental health;**
- **Name the most common serious emotional disturbances in adolescence and their potential impacts on learning and behavior; and**
- **Describe indications that a student needs additional support.**

Module II: Trainer's Outline

II-1 Introduction

A. Remind participants that the overall purpose of the training is to help eliminate barriers to learning by understanding and addressing mental health issues in the school environment.

B. Show Slides II-A (Goal) and II-B (Objectives). — SLIDE II-A, SLIDE II-B

C. Give overview of the module, linking it to themes from Module I *(Trainer Note II-1).*

II-2 Risk and Protective Factors

A. Show Slide II-C (What Are Risk Factors?). — SLIDE II-C

B. Refer to Caleb's Story from Module I (Handout I-B). Give participants time to re-read the vignette. — HANDOUT I-B

C. Ask participants what risks are present in Caleb's Story. Write responses on a flipchart and relate them to categories on the next slide.

D. Show Slide II-D (Risk and Protective Factors) and refer to corresponding Handout II-A (Risk and Protective Factors) *(Trainer Note II-2).* — SLIDE II-D, HANDOUT II-A

E. Summarize areas of potential risk and protective factors that help to reduce the likelihood of negative developmental outcomes, making the following points:

- Resilient youth are those who demonstrate favorable development despite exposure to a variety of risk factors.
- The promotion of mental health is a way to strengthen protective factors and bolster resilience for all youth.

II-3 The Adolescent Mental Health Continuum

SLIDE II-E

HANDOUT II-B

A. Show Slide II-E (Mental Health: Definition).

B. Refer to Handout II-B (Adolescent Mental Health Continuum) *(Trainer Note II-3).*

C. Explain the continuum, making the following points:

- The majority of youth experience overall wellness despite occasional difficulties.
- Behaviors of youth occupy a range of what would be expected for them during their early, middle, and late stages of adolescent development. This range can be illustrated by a continuum.
- Mental health and emotional problems are a concern when they disrupt developmental growth.
- The severity of a problem depends on three factors: the frequency (how often), duration (how long), and intensity (to what degree) of symptoms.
- Co-occurring substance use disorders can affect where youth fall in this continuum. In comparison to individuals with primary mental or substance use disorders, individuals with co-occurring disorders tend to be more symptomatic, have multiple health and social problems, and require more costly care, including hospitalization.

II-4 The Impact of Mental Health Problems and Disorders on Learning and Social Functioning

A. Show Slide II-F (Serious Emotional Disturbances: Definition). — SLIDE II-F

B. Refer to Handout II-C (Serious Emotional Disturbances). — HANDOUT II-C
   - Emphasize that SED, as used in this training, refers to a clinical diagnosis. It does not necessarily mean "qualifies for special education."

C. Ask participants to consider how mental health and emotional problems may affect academic and nonacademic activities. Write participants' responses on a flipchart and relate them to the categories on the next slide and handout *(Trainer Note II-4).*

D. Show Slide II-G (Adolescents With Mental Health and Emotional Problems) and refer to Handout II-D (Problems Associated With Serious Emotional Disturbances). — SLIDE II-G, HANDOUT II-D

E. Emphasize themes, contributions, and areas that are directly related to classroom learning.

F. On the easel or chalkboard, write the following components of learning affected by mental health and emotional problems:
   - Attentiveness
   - Concentration
   - Opportunities to rehearse
   - Demonstration of mastery
   - Classroom conduct
   - Ability to organize
   - Ability to communicate

II-5 Common Mental Health and Emotional Problems in Adolescence

A. Show Slides II-H–II-N to give a brief overview of the most common problems among teens. Refer participants to the appendix handouts for more detailed information *(Trainer Note II-5)*.

- As you show each slide, mention some of the most important ways serious emotional disturbances affect learning and behavior, referring back to the list on your easel or chalkboard. (You can find this information in Handouts II-E, II-F, II-H, and II-I.)
- Ask participants about classroom experiences that illustrate the impact of these problems on learning and behavior.

SLIDE II-H–
SLIDE II-N

HANDOUT II-E
HANDOUT II-F
HANDOUT II-H
HANDOUT II-I

II-6 Other Disorders

- Schizophrenia: Make the point that schizophrenia is rare in adolescence but that symptoms do occasionally appear; more information is available in the appendix handouts.
- Tourette syndrome, autism, and Asperger syndrome: Make the point that these are not mental health issues and will not be addressed.

II-7 When Youth Need Additional Support

A. Show Slide II-O (Indicators of Need) and refer to Handout II-J (Indicators of Need).

SLIDE II-O
HANDOUT II-J

- Make the point: There is no clear dividing line between mental health and serious emotional disturbances; they are points on a continuum.
- Remind participants they are not expected to be diagnosticians *(Trainer Note II-7)*.

B. Show Slide II-P (Action Plan). SLIDE II-P

C. Show Slide II-Q (Stages of an Action Plan) and summarize the components of a plan *(Trainer Note II-7)*. SLIDE II-Q

II-8 Closing

A. Summarize major points of the module, referring to objectives.

Module II: Trainer Preparation Notes

II-1 Introduction

Background. **Module II gives a brief overview of the serious emotional disturbances most common among adolescents and their potential effects on learning and behavior. It begins with an overview of risk and protective factors, and goes on to describe specific disorders. The module concludes with a discussion of "indicators of need"—signs suggesting that a student may need additional support. A brief introduction to an action plan, to be devised when a student needs additional support, leads to the next module, in which participants practice creating an action plan. (This last section can be omitted if Module III is to follow immediately.)**

Note on presentation**: There are opportunities within this module to include youth speakers, family speakers, and other members of a two-member or three-member presentation team (e.g., mental health professionals, family members, school professionals). A guest speaker can discuss the impact of mental health problems on learning and other areas important to the school environment. Consider Section II-5 as especially adaptable for speakers with personal experience of mental health problems during adolescence.**

II-2 Risk and Protective Factors

Background. **The exact cause of mental disorders is not known, but most experts believe that a combination of factors—biological, psychological, socio-cultural—are involved.**

While the same key events mark adolescencent development, youth develop at different rates. These differences sometimes are associated with their cultural, social, and economic groups, and/or their gender. Youth also differ in the degree to which they are insulated or protected from medical, environmental, and familial or personal events that could disrupt their developmental growth. When a group of factors have the potential to impede healthy development they are known as risk factors. Risk factors may be related to biology or environment (e.g., family, community).

Further information on risk and protective factors. **Risk does not predict poor outcomes. It simply means that a number of conditions or situations can solidify a pathway that becomes increasingly difficult to shape toward positive results.**

The areas of risk summarized on Slide II-D (Risk and Protective Factors) pertain to factors that are associated with delinquency, pregnancy, dropout, and crime. Some risk factors not mentioned include those related to individual differences, such as temperament and intelligence. Males appear more vulnerable to risk factors, as do children and youth with difficult, temperamental styles and lower IQs.

Protective factors include relationships, and opportunities to be involved and recognized for the skills and contributions made. Relationships with youth need to be genuine, authentic, and ongoing. Opportunities to be involved and contribute must match the youth's actual skill set. To fail at an opportunity due to insufficient skill sets the youth up for discouragement, frustration, and disillusionment.

The President's New Freedom Commission on Mental Health defines *resilience* as "the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses—and to go on with life with a sense of mastery, competence, and hope."[1] Resilient youth demonstrate favorable development despite exposure to a variety of risk factors. The promotion of mental health by building on strengths is a way to develop protective factors and bolster resilience for all youth.

II-3 The Adolescent Mental Health Continuum

Background. The majority of youth experience overall wellness despite occasional difficulties. Mental health problems or disorders are a concern when difficulties disrupt developmental growth. Behaviors of youth occupy a range of what would be expected for them during their early, middle, and late stages of adolescent development. This range can be illustrated by a continuum, that depicts variation in behavior frequency (how often), duration (how long), and intensity (to what degree). Along this continuum, the American Academy of Pediatrics (1996) identifies various kinds of behaviors, including behaviors expected during adolescence; behaviors that are serious enough to disrupt day-to-day functioning, representing a mental health problem; and behaviors that would suggest a mental disorder is present.

[1] New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* (DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003) 5.

Co-occurring substance use disorders can affect where youth fall along this continuum. In comparison to individuals with primary mental or substance use disorders, individuals with co-occurring disorders tend to be more symptomatic, have multiple health and social problems, and require more costly care, including hospitalization.

While secondary school teachers and staff are not expected to pinpoint where each student falls along the continuum, it is helpful to understand that problems of emotion and behavior are not merely absent or present, but are more differentiated by the frequency, duration, intensity, and impact to self and others.

About Handout II-B (Adolescent Mental Health Continuum). It is important to realize that the columns below the continuum line represent areas of functioning that have impact on life domains. These areas, more often than not, are not neatly clustered as shown in the columns and rows. Typically, some symptoms can show up at one level with other symptoms at a more intense level, and a completely different set of symptoms at an extreme level. That is, separate areas can be linked diagonally with each other. For example, a youth may show very appropriate social functioning but experience severe distress in biological patterns, as with an eating disorder.

II-4 The Impact of Mental Health Problems and Disorders on Learning and Social Functioning

Background. About 5–9 percent of children ages 9 to 17 have a serious emotional disturbance[2].

Serious emotional disturbances (SEDs) are diagnosable mental disorders *in children and adolescents* that are severe enough to disrupt daily functioning in school and non-school settings. SED, rather than mental illness, is the preferred term for severe mental health problems among children and adolescents. SEDs include mood disorders, attention-deficit/hyperactivity disorder, anxiety disorders, conduct disorders, and eating disorders.

[2] Farmer, E.M.Z. et al. The Epidemiology of Mental Health Programs and Service use in Youth: Results From the Great Smoky Mountains Study. In M.H. Epstein et al. *(eds.) Outcomes for Children and Youth With Behavioral and Emotional Disorders and Their Families. 2nd edit. (2003)

The term SED, or serious emotional disturbance, as used in this training, refers to a clinical diagnosis. It does not necessarily mean "qualifies for special education." Specific school/district policies regarding SEDs vary. In Module III, there will be an opportunity to address local policies regarding serious emotional disturbances.

Information about serious emotional disturbances' impact on academic activities. These disorders can affect important components of classroom behavior and learning, particularly attentiveness, concentration, and opportunities to rehearse and demonstrate new knowledge or skills. Self-appraisal, which is a set of attitudes and expectations about one's own ability and performance, is another important component of learning that can be affected by a serious emotional disturbance. Mastery of a skill, the prize of learning, is difficult to obtain when any or all the components of attention, concentration, self-appraisal, and rehearsal are affected by a serious emotional disturbance. Learning is a behavior, as are the social elements of conduct both inside and outside the classroom. While it might not be apparent how a disorder affects learning, the symptoms will show up in other ways, namely through behavioral conduct in the classroom and interactions with peers and adults.

Serious emotional disturbances also may affect classroom learning in more tangible ways, such as missed instruction time due to hospitalization or doctor's appointments.

II-5 Common Mental and Emotional Problems in Adolescence

In this section you will show Slides II-H–II-N, giving a very brief overview of the most common disorders among teens. The following bullets will give more background for the trainer. Much more complete information is available in the Appendix for participants' use after the training.

Discussion during this overview should center on the disorders' effects on learning and behavior. This information is included in the following handouts:

- Handout II-F (Depressive Disorders: Effects on Learning and Behavior)
- Handout II-H (Anxiety Disorders: Effects on Learning and Behavior)
- Handout II-I (Eating Disorders: Effects on Learning and Behavior)

Module II: Trainer Preparation Notes

NOTE: There is no handout on the impact of disruptive behavior disorders; the impact on behavior is part of the description of the disorder.

You can refer to the list of potential effects you have written on the easel or chalkboard as you present this section. Consider asking participants to draw on their classroom experience to illustrate some of the effects. A guest speaker could also contribute to the presentation/discussion in this section.

• Mood Disorders

Mood disorders are persistent disturbances of mood that affect an individual's ability to conduct basic life tasks. Major depressive disorder, dysthymic disorder, and bipolar disorder are the most frequently diagnosed mood disorders in children and youth.

- **Major depressive disorder** involves a pervasive sense of sadness and/or loss of interest or pleasure in most activities. This is a severe condition that can affect thoughts, sense of worth, sleep, appetite, energy, and concentration. The condition can occur as a single debilitating episode or as recurring episodes. Approximately 4 percent of adolescents experience major depression each year.[3]

- **Dysthymic disorder** involves a chronic disturbance of mood in which an individual feels little satisfaction with activities of life most of the time. Dysthymia may be one of the major pathways to recurrent depressive disorder. The average length of an episode of dysthymia is about 4 years, and children who experience dysthymia generally experience their first major depressive episode 2 to 3 years after the onset of dysthymia.

- **Bipolar disorder** is a type of mood disorder characterized by recurrent episodes of depression and mania. These episodes involve extreme changes in mood, energy, and behavior. Mania or manic symptoms include extreme irritable or elevated mood, a very inflated sense of self-importance, risky behaviors, distractibility, increased energy, and a decreased need for sleep.

[3] Kovacs, M., Kral, R., and Voti, L. (1994). Early onset psychopathology and the risk for teenage pregnancy among clinically referred girls. *Journal of the American Academy of Child and Adolescent Psychiatry,* 33: 106-113.

Information on the importance of treatment. **Identification of a mood disorder and referral to treatment can be significant first steps in restoring a youth's functioning. Fortunately, the majority of those who receive treatment for depression are treated successfully. Treatment not only alleviates symptoms, it also prevents further complications. Youth with severe depression may experience profound withdrawal from social activities, feel intense isolation and loneliness, and become at high risk for suicide.**

• Anxiety Disorders

Anxiety disorders are characterized by excessive fears, worries, and preoccupations that are a reaction to a perceived sign of danger. Anxiety itself is considered essential to adaptive functioning because it protects people from harm through a "flight or fight" biological response. An anxiety disorder, however, is a recurrent alarm that can tax the body excessively. Anxiety disorders include generalized anxiety disorder, separation anxiety disorder, panic disorder, phobias, obsessive-compulsive disorder, and post-traumatic stress disorder. If left untreated, anxiety disorders can have a significant and debilitating impact on an individual's life.

- **Obsessive-compulsive disorder** (OCD) is an anxiety disorder that is characterized by intrusive thoughts and/or behaviors that are recurrent and distressing. The thoughts act like a warning to take an action or not take an action. Compulsions are the actions undertaken to relieve the intrusive thoughts. However, these actions provide only temporary relief and may create more problems, such as taking time from obligations, responsibilities, or recreation. Actions also can have an impact that requires medical attention, such as treatment for the skin due to excessive hand washing. Obsessive thoughts, even when action is not involved, can impact functioning in critical ways.

- **Post-traumatic stress disorder** (PTSD) is anxiety that can occur in response to a threatening event that was witnessed or experienced. The event is re-experienced through nightmares, flashes of memory, or other patterns of remembering. An individual with PTSD may startle easily, experience forgetfulness, or report feeling "numb."

- **Disruptive Behavior Disorders**

Disruptive behavior disorders are a complicated group of behavioral and emotional problems that manifest as difficulty following rules and behaving in socially acceptable ways. The impact of the disruptive behavior is distressing to others and can interfere with establishing trusting and supportive relationships.

- **Conduct disorder** is a disruptive behavior disorder that can have serious consequences for youth and society. Youth with conduct disorder outwardly express their feelings about others through destructive behaviors that harm property, people, or animals. They may lie, steal, or physically fight with others. They engage in criminal or rule-violating behaviors that can lead to involvement with juvenile justice. Often they report little empathy or remorse for destructive behaviors. They may have unidentified symptoms of depression or have another diagnosable disorder, such as attention-deficit/hyperactivity disorder (ADHD) or a learning disability.

- **Eating Disorders**

Eating disorders refer to patterns of thoughts and behaviors about one's body, foods, and the intake of foods that lead to severe health, social, and school problems. Eating disorders negatively affect physical and psychological health, and if left untreated, can lead to damaging medical consequences, including death. Eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder.

- **Anorexia nervosa** is characterized by a refusal to maintain body weight at a level that is normal for one's height and age; fear of becoming overweight, even if well below normal weight; perception of body weight or body shape that is distorted; denial of being underweight; and the absence of menstrual cycles. Individuals with anorexia nervosa can become dangerously thin but continue to control their weight gain. Eating or weight gain becomes an obsession, as shown by peculiar habits, such as ritualistic food preparation, measuring food, or eating very tiny portions. Other behaviors include ways to control weight gain such as rigorous and strict exercise regimens or abuse of laxatives, enemas, and diuretics. Medical complications associated with anorexia nervosa include disturbances in the heart's rhythm, dangerously low blood pressure and body temperature, osteoporosis, and hair loss.

- **Bulimia nervosa** involves disordered eating that is typically characterized by normal weight but a distorted body image and an intense fear of gaining weight. Individuals with bulimia nervosa experience binge eating, which is the intake of large amounts of food during a specific interval of time, or they perceive a general lack of control over eating. These symptoms are coupled with behaviors to prevent weight gain, such as self-induced vomiting, misuse of laxatives or enemas, fasting, or excessive exercise.

- **Binge-eating disorder** refers to repeated episodes of binge eating, such as eating more rapidly than normal; eating until feeling uncomfortably full; or eating large amounts of food when not feeling physically hungry. The episodes are recurrent and usually occur at least two days a week for six months. Unlike bulimia nervosa, binge-eating disorder does not include ways to purge weight gain. Individuals with binge-eating disorder are usually overweight and experience extreme self-disgust or distress over their body shape and size.

II-6 Other Disorders

Note on developmental disorders. Pervasive developmental disorders (PDD) are neurobiological disturbances that range from very mild to extremely severe. These impairments affect one or more areas of intellectual, language, motor, and social functioning. Pervasive developmental disorders are sometimes referred to as autistic spectrum disorders.

These disorders are **not** classified as serious emotional disturbances, although they can co-occur with these disorders.

Disorders that fall under the pervasive developmental disorder umbrella term include autistic disorder, childhood disintegrative disorder, and Asperger syndrome. These disorders are different from one another in the magnitude of delay or deviance from normal development.

More information on each of these disorders is available from the Web sites listed on the handouts, or from the National Institutes of Health (*www.nih.gov*) or the Substance Abuse and Mental Health Services Administration's National Mental Health Information Center (*www.mentalhealth.samhsa.gov*), which also offers an online mental health services locator.

II-7 When Youth Need Additional Support

Background. Indicators of a need for intervention include behaviors, thoughts, or feelings that limit the youth's ability to maintain positive relationships, cope with the demands of home and school life, and continue healthy development.

There is no clear dividing line between mental health, mental health problems, and serious emotional disturbances and thus no easy way to tell when a student needs additional support. The indicators shown on Slide II-O (Indicators of Need) are general guidelines. Some more specific signs that youth may need help are listed in Handout II-J (Indicators of Need). You can also refer to the Adolescent Mental Health Continuum (Handout II-B) during this discussion. Note that in both handouts there are numerous references to frequency (how often a sign occurs), duration (how long it lasts), and severity. These can be clues to when a teen may need help.

Information on stages of an action plan. Detailed information on an action plan is included below for the trainer's benefit. The information is included in Handout III-A of Module III, in which it is discussed in more detail. If you have elected not to use Module III in your trainings, provide participants with the handout at this point.

Stage I: Know your building and district policies, procedures, and resources. This sounds obvious, but schools do not have the time to advertise every support service available. Every district has procedures in place to work with students and staff. For example:

- Pre-referral teams, student support teams, or other working groups may be in place.
- School psychologists, social workers, nurses, special educators, and counselors may be available within the building or at the district level.

The key for staff is to learn how to access these professionals and other school resources.

Stage II: Voice your concern. This part is hardest. Tips for teachers and other staff:

- Set aside private one-to-one time with the student, and let the student know right at the beginning of the time together that this conference is about your observations of his or her need for assistance.

- You may want to reassure the student that this conference is not a punishment or act of discipline.
- Also make known to the student that in order to help, you may have to share your concern with others, but will not share details of the conversation unless there is an immediate threat to the student's well-being.
- Discuss with the youth what action you will take together to obtain assistance.
- If you have doubts about having a one-to-one conference with the youth, seek support from internal resources or caregivers first.

Stage III: Follow up. It is important to stress that helping students isn't about shifting the problem to someone else. Following up reassures youth that you are someone who DOES care. Tips for teachers and other staff:

- Work with the youth and others involved to intervene at the classroom level. Make modifications where necessary to promote successful learning.
- Refrain from public statements that will violate the youth's privacy and confidentiality.
- Obtain support from internal resources to ensure that classroom modifications are appropriate and monitor whether adaptations are working for the youth.
- Check with internal resources to ensure that help is being accessed.

The action plan should be tailored to the needs of the student and his or her family and should include all the resources inside and outside the school that can meet his or her needs. Not all students will show an immediate beneficial response to intervention. Continue to provide support for the student within the classroom and provide feedback to the student at every hint of progress.

Researchers and educators have identified a number of specific intervention strategies and options. Functional behavior assessment and Positive Behavioral Interventions and Supports (PBIS) are among the practices that may be employed by teachers and schools. Find out your own school's policy for interventions, and see the Resource List, included as an appendix to this training, for more information.